

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042028</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Alden-North Shore Rehab & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>5050 W. Touhy Ave.</u> <u>SKOKIE</u> <u>60077</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u> (Title) <u>Chief Financial Officer</u>																									
Telephone Number: <u>(847) 679-6100</u> Fax # <u>(847) 679-3822</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
IDPA ID Number: <u>36-3978207</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>08/06/99</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Alden-North Shore Rehab & HCC# 0042028 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>34,038</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>34,038</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>3,847</u>	<u>6,420</u>	<u>10,267</u>	8
9	SNF/PED					9
10	ICF		<u>2,286</u>	<u>65</u>	<u>2,351</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		<u>6,133</u>	<u>6,485</u>	<u>12,618</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 37.07%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/14/99

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/14/99 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 93 and days of care provided 6,485Medicare Intermediary AdminiStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Alden-North Shore Rehab & HCC

0042028

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	381,666	33,655		415,321	1,284	416,605		416,605			1
2	Food Purchase		179,181		179,181	(17,327)	161,854	2,760	164,614			2
3	Housekeeping	74,360	13,779		88,139	776	88,915		88,915			3
4	Laundry	27,181	13,393		40,574	483	41,057		41,057			4
5	Heat and Other Utilities			135,774	135,774		135,774		135,774			5
6	Maintenance	45,491		131,812	177,303	1,157	178,460	248	178,708			6
7	Other (specify):*											7
8	TOTAL General Services	528,698	240,008	267,586	1,036,292	(13,627)	1,022,665	3,008	1,025,673			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,060,194	51,451	2,215	1,113,860	7,629	1,121,489	(222)	1,121,267			10
10a	Therapy	33,208			33,208	1,020	34,228		34,228			10a
11	Activities	63,193	3,674	2,472	69,339		69,339	1,020	70,359			11
12	Social Services	39,130		618	39,748		39,748		39,748			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,195,725	55,125	23,305	1,274,155	8,649	1,282,804	798	1,283,602			16
	C. General Administration											
17	Administrative	75,895			75,895		75,895		75,895			17
18	Directors Fees											18
19	Professional Services			355,478	355,478	(11,020)	344,458	(330,039)	14,419			19
20	Dues, Fees, Subscriptions & Promotions			60,717	60,717	(1,073)	59,644	(49,592)	10,052			20
21	Clerical & General Office Expenses	231,258	23,119	28,420	282,797	292	283,089	38,368	321,457			21
22	Employee Benefits & Payroll Taxes			296,597	296,597	6,779	303,376	20,220	323,596			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,507	1,507		1,507	3,356	4,863			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,582	26,582		26,582	9,254	35,836			26
27	Other (specify):*											27
28	TOTAL General Administration	307,153	23,119	769,301	1,099,573	(5,022)	1,094,551	(308,433)	786,118			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,031,576	318,252	1,060,192	3,410,020	(10,000)	3,400,020	(304,627)	3,095,393			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden-North Shore Rehab & HCC #0042028 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,294	9,294		9,294	213,737	223,031			30
31	Amortization of Pre-Op. & Org.							11,450	11,450			31
32	Interest			216,170	216,170		216,170	427,084	643,254			32
33	Real Estate Taxes					10,000	10,000	150,913	160,913			33
34	Rent-Facility & Grounds			1,011,857	1,011,857		1,011,857	(1,011,857)				34
35	Rent-Equipment & Vehicles			4,954	4,954		4,954	4,601	9,555			35
36	Other (specify):* MORT. INS.							41,631	41,631			36
37	TOTAL Ownership			1,242,275	1,242,275	10,000	1,252,275	(162,441)	1,089,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		293,140	623,621	916,761		916,761	(320,272)	596,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,057	51,057		51,057		51,057			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		293,140	674,678	967,818		967,818	(320,272)	647,546			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,031,576	611,392	2,977,145	5,620,113		5,620,113	(787,340)	4,832,773			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(54,523)	30		9
10	Interest and Other Investment Income	(3,001)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,070)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(359)	32		18
19	Entertainment				19
20	Contributions	(8)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,918)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,560)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,439)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(357,552)	vary	34
35	Other- Attach Schedule	(322,349)	vary	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (679,901)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (787,340)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1			1	
1 non-costs for lmo therapy c/a 5026	\$ (13,985)	39		
2 non-costs for lmo drugs c/a 5042	(6,570)	39	2	
3 non-costs for lmo therapy c/a 5040	(87,081)	39	3	
4 non-costs for lmo oxygen c/a 5080	(3,453)	39	4	
5 use fees (political contributions)	(1,166)	20	5	
6 Skokie chamber of commerce dues	(675)	30	6	
7 Skyline Valet-valet non-allowable	(48,290)	19	7	
8 reclass massage therapy from ln 19 to ln 11	1,020	11	8	
9 reclass massage therapy from ln 19 to ln 11	(1,020)	19	9	
10 community relation (non allowable expense)	(395)	20		
11 reclass painting>\$1,500 for 2000 from ln 6 to pg 22	(2,370)	6	11	
12 record deprec exp on painting reclassified in 2000	363	6	12	
13 adj rent to equal actual	(4,813)	34	13	
14			14	
15 back out non-allowable interest on shareholder loans	(153,890)	32	15	
16 adj. Deprec exp to actual for 2000	(1,251)	30	16	
17			17	
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89			89	
90 Total	(322,349)		90	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,070)	0	0	4,830	0	0	0	0	0	0	0	2,760	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,813)	0	2,061	0	0	0	0	0	0	0	0	248	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,883)	0	2,061	4,830	0	0	0	0	0	0	0	3,008	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(222)	0	0	0	0	0	0	(222)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,020	0	0	0	0	0	0	0	0	0	0	1,020	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	1,020	0	0	0	(222)	0	0	0	0	0	0	798	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(49,310)	(483)	(280,195)	0	0	0	0	(51)	0	0	0	(330,039)	19
20	Fees, Subscriptions & Promotions	(49,722)	0	130	0	0	0	0	0	0	0	0	(49,592)	20
21	Clerical & General Office Expenses	0	1,476	8,770	12,293	15,829	0	0	0	0	0	0	38,368	21
22	Employee Benefits & Payroll Taxes	0	0	20,985	0	(765)	0	0	0	0	0	0	20,220	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,356	0	0	0	0	0	0	0	0	3,356	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,218	36	0	0	0	0	0	0	0	0	9,254	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(99,032)	10,211	(246,918)	12,293	15,064	0	0	(51)	0	0	0	(308,433)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(101,895)	10,211	(244,857)	17,123	14,842	0	0	(51)	0	0	0	(304,627)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(55,774)	254,196	15,315	0	0	0	0	0	0	0	0	213,737 30
31	Amortization of Pre-Op. & Org.	0	8,107	0	0	0	0	3,343	0	0	0	0	11,450 31
32	Interest	(157,210)	577,585	1,176	0	0	0	5,533	0	0	0	0	427,084 32
33	Real Estate Taxes	0	149,458	1,455	0	0	0	0	0	0	0	0	150,913 33
34	Rent-Facility & Grounds	(4,813)	(1,007,044)	0	0	0	0	0	0	0	0	0	(1,011,857) 34
35	Rent-Equipment & Vehicles	0	0	4,601	0	0	0	0	0	0	0	0	4,601 35
36	Other (specify):*	0	41,631	0	0	0	0	0	0	0	0	0	41,631 36
37	TOTAL Ownership	(217,797)	23,933	22,547	0	0	0	8,876	0	0	0	0	(162,441) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(110,096)	0	0	(19,446)	(56,192)	0	(134,538)	0	0	0	0	(320,272) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(110,096)	0	0	(19,446)	(56,192)	0	(134,538)	0	0	0	0	(320,272) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(429,788)	34,144	(222,310)	(2,323)	(41,350)	0	(125,662)	(51)	0	0	0	(787,340) 45

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning:

01/01/00

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12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERVICES, INC.	100%	SEE PAGE 6K		SEE PAGE 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENTAL INCOME	\$ 1,007,044	NORTHSHORE, ASSCO.		\$	\$ (1,007,044)	1
2	V	32	INTEREST INCOME	5,715	NORTHSHORE, ASSCO.			(5,715)	2
3	V	21	G&A		NORTHSHORE, ASSCO.		1,476	1,476	3
4	V	33	REAL ESTATE TAX		NORTHSHORE, ASSCO.		149,458	149,458	4
5	V	30	DEPRECIATION		NORTHSHORE, ASSCO.		254,196	254,196	5
6	V	36	MORTGAGE INSURANCE		NORTHSHORE, ASSCO.		41,631	41,631	6
7	V	26	GENERAL INSURANCE		NORTHSHORE, ASSCO.		9,218	9,218	7
8	V	31	AMORTIZATION		NORTHSHORE, ASSCO.		8,107	8,107	8
9	V	19	ACCOUNTING FEE		NORTHSHORE, ASSCO.		(483)	(483)	9
10	V	32	INTEREST ON MORTGAGE		NORTHSHORE, ASSCO.		583,300	583,300	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,012,759			\$ 1,046,903	\$ * 34,144	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-North Shore Rehab & HCC

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 maintenance/utilities	\$	Alden Management Services, Inc.		\$ 2,061	\$ 2,061
16	V	19 professional fees	283,020	Alden Management Services, Inc.		2,825	(280,195)
17	V	20 licenses/fees		Alden Management Services, Inc.		130	130
18	V	21 gen'l & admin		Alden Management Services, Inc.		8,770	8,770
19	V	22 employee costs		Alden Management Services, Inc.		20,985	20,985
20	V	24 auto/seminar		Alden Management Services, Inc.		3,356	3,356
21	V	26 insurance		Alden Management Services, Inc.		36	36
22	V	30 depreciation		Alden Management Services, Inc.		15,315	15,315
23	V	32 interest		Alden Management Services, Inc.		1,176	1,176
24	V	33 real estate tax		Alden Management Services, Inc.		1,455	1,455
25	V	35 auto lease		Alden Management Services, Inc.		4,601	4,601
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 283,020			\$ 60,710	\$ * (222,310)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube feeding	\$	Pyramid Healthcare Services		\$ 4,830	\$ 4,830	15
16	V	39 nursing supplies		Pyramid Healthcare Services		2,318	2,318	16
17	V	supplies / per diem fees	60,456	Pyramid Healthcare Services		38,692	(21,764)	17
18	V	21 gen'l & admin		Pyramid Healthcare Services		12,293	12,293	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 60,456			\$ 58,133	\$ * (2,323)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-North Shore Rehab & HCC

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 181,262	Forum Extended Care II		\$ 136,441	\$ (44,821)
16	V	10 house stock	899	Forum Extended Care II		677	(222)
17	V	39 iv	45,987	Forum Extended Care II		34,616	(11,371)
18	V	22 vaccinations	3,092	Forum Extended Care II		2,327	(765)
19	V	21 gen'l & admin		Forum Extended Care II		15,829	15,829
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 231,240			\$ 189,890	\$ * (41,350)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-North Shore Rehab & HCC

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 CPT REVENUES	\$ 478,099	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 343,561	\$ (134,538)	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		3,343	3,343	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		5,533	5,533	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 478,099			\$ 352,437	\$ * (125,662)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning: 01/01/00

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Construction management fees	\$ 3,600	Alden Bennett Construction	0.00%	\$ 3,549	\$ (51)	15
16	V	19 architect/design	5,303	Alden Design Group	0.00%	5,303		16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,903			\$ 8,852	\$ * (51)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Alden-North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President - AMS	CFO	100.00	191,891	0.524	1.31	Salary	\$ 2555	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	73,511	0.524	1.31	Salary	979	21-1	2
3	Terry Magnusson	Administrator/other	admini / mainten.	b.	73,217	0.524	1.31	Salary	403	21-1	3
4	Joan Carl	Vice - President	Secretary	c.	104,544	2.424	1.31	Salary	1392	21-1	4
5	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	d.	5,670	0.45	0.17	fees	1,181	10a-3	5
6											6
7	a. Lauren is the daughter of Schlossberg and worked as clinical coordinator for Alden Management Services in 2000.										7
8	b. Terry is the son-in-law of Floyd Schlossburg. He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										8
9	c. Joan Carl is the secretary of AMS and all of the Nursing Facilities. She is the partner in Valley Ridge, Princeton, Cicero, North Shore, Orland Park and Northmoor										9
10	Associates.										10
11	d. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										11
12											12
13								TOTAL	\$ 6,510		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden-North Shore Rehab & HCC# 0042028

Report Period Beginning:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ALDEN MANAGEMENT SERVICES, INC.

Street Address _____

City / State / Zip Code _____

Phone Number (773)286-3883Fax Number (773)286-3742

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	SEE PAGE 8A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	MORTGAGE INTEREST	X		MORTGAGE/GUILDING	\$62,000.00	3/1/98	\$ 7,990,941	\$ 8,344,022	2/28/27	7.2500	\$ 583,300	1	
2												2	
3												3	
4	NS Corp-- LINE OF CREDIT	X		OPERATION	NONE					VARIES	38,766	4	
5												5	
	Working Capital												
6	Corp-Bank Leumi loan		X	OPERATIONS	NONE	8/1/99	620,000	620,000	4/6/01	9.0000	23,195	6	
7												7	
8	RELATED PARTY	X		OPERATIONS	NONE					VARIES	6,709	8	
9	TOTAL Facility Related				\$62,000.00		\$ 8,610,941	\$ 8,964,022			\$ 651,970	9	
	B. Non-Facility Related*												
10	INTEREST INCOME	X		NON-CARE INTEREST							(5,715)	10	
11	MISC. ADJUSTMENT	X									(3,001)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (8,716)	14	
15	TOTALS (line 9+line14)						\$ 8,610,941	\$ 8,964,022			\$ 643,254	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	94,541	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	67,899	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(26,642)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	176,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	10,000	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	159,458	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	N/A	8		
	1996	N/A	9		
	1997	N/A	10		
	1998	11,976	11		
	1999	67,899	12		

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

LINE4: 2000 ACCRUAL BASED ON AN ESTIMATED INCREASE IN THE REAL ESTATE TAXES. PRIOR YEARS TAXES WERE BASED ON UNDEVELOPED LAND, THUS HAD A LOWER VALUE.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet:

45,208

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

40,437

2. Number of Years Over Which it is Being Amortized:

5

3. Current Period Amortization:

8,107

4. Dates Incurred:

1999

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF	34,483	1997	\$ 955,797	1
2					2
3	TOTALS	34,483		\$ 955,797	3

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1999	1999	\$ 6,782,967	\$ 195,977	40	\$ 169,574	\$ (26,403)	\$ 169,574	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		draper corp-electric screen		1999	1,252	125	10	125		167	9
10		dakota wiring & comm.-wiring for cable tv		1999	2,500	250	10	250		313	10
11		climate serv-repair compressor		1999	1,990	133	15	133		144	11
12		tci cable-install cable		1999	1,254	125	10	125		146	12
13		ABC-install tiles/repair		2000	4,011	223	15	223		223	13
14		ABC-mainten-various/construction		2000	5,000	417	10	417		417	14
15		ABC-mainten-various/construction		2000	10,000	750	10	750		750	15
16		ABC-mainten-various/construction		2000	10,000	667	10	667		667	16
17		new horizons-phone system		2000	5,744	431	10	431		431	17
18		new horizons-phone system & cable		2000	2,784	186	10	186		186	18
19		new horizons-phone system		2000	3,742	249	10	249		249	19
20		dbs contract-lawn sprinkler system		2000	1,611	54	15	54		54	20
21		ABC-misc construction work		2000	5,347	178	5	178		178	21
22		ABC-misc construction work		2000	13,118	219	5	219		219	22
23											23
24											24
25		continue...									25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 6,851,318	\$ 199,983		\$ 173,580	\$ (26,403)	\$ 173,716	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	\$ 12,184	\$ 554	22	\$ 554		\$ 11,565	4
5	Party-			1978	5,953	271	32	271		4,767	5
6	Forum										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 58,177	\$ 3,514		\$ 3,514		\$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 513,013	\$ 67,919	\$ 39,799	\$ (28,120)	vary	\$ 105,383	37
38	Current Year Purchases	28,616	2,430	2,430		vary	2,430	38
39	Fully Depreciated Assets	20,651	1,214	1,214		vary	20,651	39
40								40
41	TOTALS	\$ 562,280	\$ 71,563	\$ 43,443	\$ (28,120)		\$ 128,464	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	\$ 26,682	\$ 2,494	\$ 2,494		3	\$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			\$ 26,682	\$ 2,494	\$ 2,494			\$ 3,030	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 8,454,255	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 277,554	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 223,031	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (54,523)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 520,442	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1999</u>	<u>93</u>	<u>7/1/99</u>	\$ <u>343,236</u>	<u>40</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>93</u>		\$ <u>343,236</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 4,954 Description: COPY MACHINE LEASE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>RELATED PARTY</u>		\$	\$	17
18	<u>SEE PAGE 8A</u>	<u>VARIOUS</u>	<u>383.00</u>	<u>4,601</u>	18
19					19
20					20
21	TOTAL		\$ <u>383.00</u>	\$ <u>4,601</u>	21

10. Effective dates of current rental agreement:

Beginning 7/1/1999

Ending 6/30/2009

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/01 \$ 943,250

13. 12/31/02 \$ 966,850

14. 12/31/03 \$ 991,050

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>SKILLED NURSING IS ALREADY ON SITE</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 228,374	\$		\$ 228,374	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			23,377			23,377	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			226,347			226,347	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG16A	# of prescrpts				101,910		101,910	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEEPG 16A					16,481		16,481	13
14	TOTAL			\$		\$ 478,098	\$ 118,391		\$ 596,489	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,920	\$ 24,528	1
2	Cash-Patient Deposits	666	666	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	640,972	640,972	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,949	97,805	6
7	Other Prepaid Expenses	18,563	46,326	7
8	Accounts Receivable (owners or related parties)		31,460	8
9	Other(specify): <u>misc. receiv / other escrows</u>	3,750	5,935	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 733,820	\$ 847,692	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,839,086	14
15	Leasehold Improvements, at Historical Cost	70,100	70,100	15
16	Equipment, at Historical Cost	59,472	971,778	16
17	Accumulated Depreciation (book methods)	(10,858)	(349,786)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		165,802	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,810)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 118,714	\$ 9,641,968	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 852,534	\$ 10,489,660	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,797,177	\$ 1,799,338	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	520	520	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,819	112,819	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,825	48,825	31
32	Accrued Real Estate Taxes(Sch.IX-B)		176,100	32
33	Accrued Interest Payable		100,109	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>third party</u>	1,978,674	1,978,674	36
37	<u>due idpa / other accr exps</u>	25,330	49,164	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,963,345	\$ 4,265,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,344,022	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,344,022	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,963,345	\$ 12,609,571	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,110,811)	\$ (2,119,911)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 852,533	\$ 10,489,660	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,441,591)	1
2	Restatements (describe):		2
3	External auditor's adjustments made after 1999 cost report		3
4	was filed. The adjustments had no effect on reimbursable		4
5	cost: bad debt expense and mediacre revenues were adjusted:	273,497	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,168,094)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,942,717)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,942,717)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,110,811)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,249,202	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,249,202	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	7,138	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,138	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	556	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	256,692	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 257,248	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,001	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,001	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Adj's made to prior year expenses. Since prior year reports</u>		28
28a	<u>were not used, we've made no offsetting adjs on pg 5 or 5a</u>	290	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 290	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,516,879	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	1,036,292	31
32	Health Care	1,274,155	32
33	General Administration	939,056	33
B. Capital Expense			
34	Ownership	1,242,275	34
C. Ancillary Expense			
35	Special Cost Centers	916,761	35
36	Provider Participation Fee	51,057	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,459,596	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,942,717)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,942,717)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden-North Shore Rehab & HCC

0042028

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,400	1,478	\$ 46,740	\$ 31.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,052	18,508	446,462	24.12	3
4	Licensed Practical Nurses	2,534	2,656	57,638	21.70	4
5	Nurse Aides & Orderlies	37,738	38,801	453,337	11.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	602	640	7,489	11.70	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,080	33,415	16.06	9
10	Activity Assistants	4,875	4,944	29,778	6.02	10
11	Social Service Workers	2,257	2,534	39,130	15.44	11
12	Dietician	4,877	4,955	41,499	8.38	12
13	Food Service Supervisor	2,148	2,394	43,970	18.37	13
14	Head Cook	7,348	7,637	134,961	17.67	14
15	Cook Helpers/Assistants	15,501	16,054	161,236	10.04	15
16	Dishwashers					16
17	Maintenance Workers	2,040	2,223	45,492	20.46	17
18	Housekeepers	10,077	10,391	74,359	7.16	18
19	Laundry	3,511	3,650	27,181	7.45	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,488	5,978	108,913	18.22	22
23	Office Manager	3,755	3,869	51,658	13.35	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,513	1,536	42,082	27.40	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Clinical Supp. Sup</u>	605	653	25,719	39.39	33
34	TOTAL (lines 1 - 33)	126,337	130,981	\$ 1,871,059 *	\$ 14.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	2,884	11-3	44
45	Social Service Consultant	12	618	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 3,502		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
SALLY MYERS	ADMINISTRATOR		\$ 31,250	Workers' Compensation Insurance		\$ 6,441	IDPH License Fee		\$
CAREN PERLMUTER	ADMINISTRATOR		44,645	Unemployment Compensation Insurance		42,245	Advertising: Employee Recruitment		2,791
				FICA Taxes		137,903	Health Care Worker Background Check		
				Employee Health Insurance		84,045	(Indicate # of checks performed)		
				Employee Meals		17,327	Misc. Subscription (IHCA and others)		5,085
				Illinois Municipal Retirement Fund (IMRF)*			Misc. Inspection		1,511
				DENTAL / LIFE INSURANCE		2,458	Village of Skokie		535
TOTAL (agree to Schedule V, line 17, col. 1)						5,242	Related Party		130
(List each licensed administrator separately.)						7,715			
\$ 75,895				RELATED PARTY		20,220			
B. Administrative - Other							Less: Public Relations Expense		()
							Non-allowable advertising		()
Description				Amount			Yellow page advertising		()
				\$			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,052
TOTAL (agree to Schedule V, line 17, col. 3)				\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 323,596	
(Attach a copy of any management service agreement)						E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
C. Professional Services									
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description	Amount
ALDEN MANAGEMENT SVS.	MGMT. FEES		\$ 283,020				\$	Out-of-State Travel	\$
BLACKMAN KALLICK	ACCOUNTING FEES		2,900						
KENNETH FISCH	LEGAL		179						
Audra Schlossberg-Elisco **	massage therapy-reclassified		1,020					In-State Travel	
VARIOUS PROFESSIONAL FEES	PRO. FEES		747					AUTO & TRAVEL	1,123
ALDEN DESIGN	DESIGN FEES		5,303						
ALDEN BENNET CONSTRUCTION	CONSTRUCT. FEES		3,600						
US GAS & ENERGY	UTILITY CONSULT		419					Seminar Expense	
Skyline Valet-backed out on pg 5a	valet service-backed out on pg5a		48,290					SEMINARS	384
Schain, Burney, Ross&Citron	R.E. tax assessment		10,000						
** reclassified to line 10a on page 3, col. 5.								RELATED PARTY	3,356
TOTAL (agree to Schedule V, line 19, column 3)								Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)								(agree to Sch. V, line 24, col. 8)	
\$ 355,478				TOTAL			\$	TOTAL	\$ 4,863

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	ABC (masonry and r&m)	9/00	\$ 1,749	3	\$	\$	\$	\$ 194	\$ 583	\$ 583	\$ 389	\$ 0	\$
2	painting>\$1500 for 2000	7/00	2,176	3				363	725	725	363	0	
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,925		\$	\$	\$	\$ 557	\$ 1,308	\$ 1,308	\$ 752	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Assoc. \$5,760
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES(pg5a)
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,858 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES NO NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,057
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,327 Has any meal income been offset against related costs? NONE Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.